MDR Tracking Number: M5-04-1877-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-23-04. .

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO has determined that the unlisted therapeutic procedures, hydrotherapy, manipulation, therapeutic activities, joint mobilization, myofascial release, electrical stimulation, manual traction, chiropractic manipulative treatment (spinal), therapeutic exercises, nervous system surgery, hot/cold pack therapy, analysis of clinical data, manual therapy technique, prolonged physician service, electrodes, office visits with and without manipulation that were denied with "V" and rendered from 5/30/03 through 12/10/03 were medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 8, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99214 for date of service 2/27/03 was denied by the carrier with "F" fee guideline reduction and "G" unbundling for code 64550. However, this code is not global to 64550 as this is not a surgical procedure. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for this code. Therefore, **reimbursement is recommended** in the amount of $71.

CPT code 99080-73 for dates of service 6/20/03, 7/10/03, 7/18/03, 8/1/03, 8/15/03, 9/26/03, 10/13/03, 10/29/03, 11/5/03 and 11/19/03 was denied by the carrier with "V", unnecessary medical treatment per peer review, however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. **Reimbursement is recommended** for ten dates of service from 6-20-03 through 11-19-03 for a total of $150.

CPT code 97036 for date of service 11/7/03 was denied by the carrier with "F", fee guideline reduction. However, no payment was made. Review of the documentation does not reflect proof of billing in accordance with Rule 133.308 (f)(3)—no recon HCFA in file for this service, nor is there a reconsideration EOB to confirm receipt. Therefore, **reimbursement is not recommended.**

CPT code 99080 for date of service 7/24/03 was denied by the carrier with "V", unnecessary medical treatment per peer review. However, per Rule 133.306(a), records are not subject to IRO review and the Medical Review Division has jurisdiction in this matter. According to the General Instructions of the 1996 MFG III A, "Documentation of procedure in the MAR column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." The requestor did not submit documentation in accordance with the above rule. Therefore, **reimbursement is not recommended**.

CPT code 99354 for dates of service 3/10/03 through 4/4/03 was denied by the carrier with "G", unbundling. The carrier stated that these services were paid under office visits and there was insufficient documentation to support prolonged service. According to the 2003 Encoder Pro program, this code requires a primary procedure code. The documentation submitted does not support prolonged service. Therefore, **reimbursement is not recommended**.

This Findings and Decision is hereby issued this 22nd day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 2/27/03 through 12/10/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of October 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division
HHB/rlc

May 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1877-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 36 year-old male who sustained a work related injury on ___. The patient reported that while at work he sustained a repetitive motion injury to his back. X-rays of the spine on 11/25/02 indicated no evidence of spinal fracture, disc wedging at L3-4, T3-4 with left rotation of T-3, Schmorl's nodes at T-12 through L-3 with associated developmental narrowing of the T-12, L-1 and possibly L-1 and L-2 discs, hypolordotic cervical spine, retrolisthesis of C-3 with right laterolisthesis of C-1, and mild thinning of the C-3-4 and C5-6. A MRI scan of the lumbar spine on 1/16/03 indicated a 1mm bulge at L2-3, a 1-2mm broad based disc protrusion at L3-4, a 1mm bulge at L4-5 and 1-2mm broad based protrusion at L5-S1, and facet arthrosis noted at L3-4, L4-5, and L5-S1. The patient underwent an NCV on 2/24/03 that revealed a left L5 radiculopathy. The diagnoses for this patient have included low back pain, displacement of lumbar intervertebral disc without myelopathy, closed dislocation, lumbar vertebra, closed dislocation, sacrum, and thoracic or lumobsacral neuritis or radiculitis, unspecified. Treatment for this patient's condition has included hot/cold packs, electrical stimulation, ultrasound, massage, manipulation, myofascial release, hydrotherapy, joint mobilization, and therapeutic procedures and exercises.

Requested Services

Unist ther proc, hydrotherapy, manipulation, ther act, joint mobil, myofas rel, elec stim unattended, traction manual, chiro man treatment spinal, ther exer, nerv syst surg, hot/cold pack ther, analysis clinical data, man ther tech, prolonged phys serv, electrodes, elec stim unatten, ov with manipulation, ov from 5/30/03 through 12/10/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Neurology notes 2/11/03, 6/11/03, 8/7/03
2. X-Ray report 11/25/02
3. NCV report 2/24/03
4. MRI report 1/16/03

Documents Submitted by Respondent:

1. SOAP notes 3/24/03 – 12/15/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 36 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included low back pain, displacement of lumbar intervertebral disc without myelopathy, closed dislocation, lumbar vertebra, closed dislocation, sacrum, and thoracic or lumbosacral neuritis or radiculitis, unspecified. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included hot/cold packs, electrical stimulation, ultrasound, massage, manipulation, myofascial release, hydrotherapy, joint mbobilization, and therapeutic procedures and exercises. The ___ chiropractor reviewer explained that the injuries this patient sustained were extensive. The ___ chiropractor reviewer also explained that due to this patient's diagnoses, extensive and lengthy treatment would be required. Therefore, the ___ chiropractor consultant concluded that the Unist ther proc, hydrotherapy, manipulation, ther act, joint mobil, myofas rel, elec stim unattended, traction manual, chiro man treatment spinal, ther exer, nerv syst surg, hot/cold pack ther, analysis clinical data, man ther tech, prolonged phys serv, electrodes, elec stim unatten, ov with manipulation, ov from 5/30/03 through 12/10/03 were medically necessary to treat this patient's condtion.

Sincerely,